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ABSTRACT

The failure of deinstitutionalization to provide an appropriate place for the mentally ill to live in the communities is the topic of this report. The history of how community-based housing programs fell victim to the same coordination problems that generally plagued deinstitutionalization efforts is discussed. Problems discussed include: (1) communities did not have initial resources to establish many residential programs; (2) federal support transferred to the communities provided inducement to close state hospitals; and (3) mentally ill persons had to pay for housing with federal aid benefits which were inadequate to provide access to even low-income housing. Legislative guidelines to remedy the housing problem are suggested including transitional supervised houses and family care homes. Specific state laws addressing this problem are discussed. It is noted that federal money for public housing and mental health services will probably decrease while the demand for housing will increase, and that recent court cases have supported community-based housing for the mentally ill. A Virginia case study and references are included. (ABL)

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Human Resources Series

HOUSING FOR THE MENTALLY ILL: A PLACE CALLED HOME

by

Andrea Paterson and Ellen Rhubright

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HOUSING FOR THE MENTALLY ILL: A PLACE CALLED HOME

INTRODUCTION

Outside the state hospital walls was hope. The deinstitutionalization movement of the 1960s and 1970s was to usher in a new era. The new community mental health center (CMHC) would provide mental health care and medication management, while linking the mentally ill individual with necessary psychosocial and rehabilitative services. An assortment of housing programs, involving varying degrees of supervision and structure, would encourage the individual to achieve his or her greatest possible level of functioning. Mental illness would be kept in check while potential for self-sufficiency was gently fostered.

Statistically, the deinstitutionalization movement has achieved its goal: in the last 25 years, the number of state hospital residents has decreased by three-quarters (1, p. 62). And for many mentally ill, who would have traditionally resided in the state hospitals, life in the community has proved significantly better.

Yet the deinstitutionalization of the mentally ill was to involve two stages: the termination of many of the services traditionally provided by the state hospitals and the development of a new set of services to be provided in the communities. In many communities, however, these new services were simply not developed. Inadequate funding was part of the problem. Also partially responsible was the once widely held--and now largely disputed--belief that the seriously and chronically mentally ill could be "cured" if treated in a community-based setting.

Whatever the cause, the result was the release of many state hospital residents to communities that had no functional alternatives to the hospital's services. Certain populations--most notably the seriously and chronically mentally ill--found community life highly problematic. Many of them still receive only partially coordinated and incomplete community-based care. And all have come to understand one fundamental truth: housing for the mentally ill is woefully scarce. Outside the state hospital walls there may be no appropriate place to live.

GENERAL OVERVIEW

Historical Perspective: Housing Shortages and Shortfalls from the Beginning. The proponents of deinstitutionalization were justifiably horrified by the state hospitals' track records of abuse and neglect and encouraged by the development of a new treatment philosophy that would be augmented by the use of psychotropic drugs. The federal Community Mental Health and Mental Retardation Centers Construction Act of 1963 marked a shift in national policy toward "a bold new approach" in combating and preventing mental illness through a network of community-based treatment centers. The success of these centers would necessarily depend upon the availability of a range of residential treatment programs, linked with an array of supportive services.

One of the roadblocks preventing the successful reintegration and community-based treatment of the mentally ill thus far has been and continues

to be the lack of appropriate housing. Many problems have complicated the achievement of this goal.

To begin with, community-based housing programs fell victim to the same coordination problems that generally plagued deinstitutionalization efforts.

- Optimism regarding the treatment effectiveness of the CMHCs led to a belief that they would eventually replace the state hospitals. Efforts to integrate the state and local systems of care thus became of secondary importance. States were often bypassed in the task of establishing community-care programs since localities generally dealt directly with the federal government in obtaining grants for the establishment of the CMHCs (2, p. 3405). Yet the federal-local effort to establish community-care programs compounded coordination problems already complicating state-local efforts to transfer state hospital residents to appropriate community-based settings. This lack of synchronization produced a major housing crunch when the first wave of patients was released from the state hospitals and into communities that had, as yet, no place for many of them to live.

- Federal support for the mentally ill transferred to the communities provided a powerful inducement for states to continue or to accelerate efforts to "close" their state hospitals. Many states felt continuing political and economic pressure to deinstitutionalize even when appropriate housing and support services would not necessarily be available to the state hospital residents released to the communities.

- Across the country, key court cases, such as Wyatt v. Stickney and Donaldson v. O'Connor, mandated minimum levels of care in state hospitals, as well as treatment settings that were the "least restrictive." A whole body of law began to emerge that established the rights of mental health clients, especially during involuntary commitment proceedings. Newly implemented legal safeguards made state commitment laws increasingly stringent. States could no longer legally keep residents in state hospitals beyond a certain period--they had to be released, even to communities that had no real way to care for them.

- Federal aid programs serving the mentally ill--Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)--had in the past and continue to have complicated application procedures and long waiting periods that are generally at odds with the timetables of hospital discharge policies (2, p. 3410). Many applicants may have to wait eight to 24 months for a determination, with as many as 80 percent of the applicants initially turned down. As a result, patients can be and often were released without any means of support. Moreover, a brief return to the state hospital can mean the loss of federal SSI and SSDI benefits.

- Many states found it politically and financially difficult to transfer to the communities the resources that had been with the patients in the state hospitals. Thus communities did not have the initial resources they needed to establish many residential and support programs.

- Federal and state funds were generally channeled into separate service providers within the community-care system, exacerbating existing coordination problems.

Secondly, housing programs fell victim to local problems, which were and continue to be tremendously exacerbated by the chronic poverty of many mentally ill. In many parts of the country, the tasks of finding suitable facilities in appropriate locations and of getting the mentally ill settled in those facilities proved to be and continue to be particulary onerous.

- The vast majority of the mentally ill would have to pay for their housing out of marginal federal aid benefits, often too limited even to allow them access to low-income housing. Among the scarce housing resources that did exist, many facilities were simply too expensive. In addition, the mentally ill were in competition with other disabled groups, many of whom could offer a better financial deal.

- The rundown urban neighborhoods, containing most of the potential housing stock for homes for the mentally ill, hardly constituted an ideal location for individuals often singularly unable to defend themselves.

- The communities greatly resisted efforts to integrate the mentally ill. Exclusionary zoning barred small group homes from many residential neighborhoods altogether. Larger facilities were kept from locating in better downtown neighborhoods through complicated and often discriminatory zoning regulations, requiring them to obtain zoning permits or variances. Requests for such permits or variances were frequently refused.

Thirdly, housing programs fell victim to some of the same misconceptions about the nature of mental illness that generally helped shape deinstitutionalization policies. At the beginning of the movement, many still believed that community-based care was the key to "curing" the mentally ill. Thus many involved in deinstitutionalization planning failed to anticipate--and take the necessary steps to coordinate--the various service providers that would necessarily be involved in creating a truly comprehensive system of care in the community.

- Housing programs suffered when efforts to establish a continuum of community-based services failed. The absence of other community-care components greatly limited the placement success of those mentally ill who did obtain some kind of basic housing. Without continuing mental health services, without a place to go during the day, without any kind of crisis assistance, many mentally ill deteriorated to where they could not remain in what had once been plausible housing arrangements.

- A general optimism about the benefits of community life led many involved in deinstitutionalization planning to simplify the complex housing needs of the mentally ill. A continuum of housing programs would need to be developed to provide a range of short-term, transitional and long-term residential services.

The interplay of these various housing problems had dire consequences for the mentally ill. Many ended up back with their families, or in minimal service facilities such as board-and-care homes or single-room occupancy hotels. Others, overwhelmed with negotiating the complex service delivery system, soon found themselves trapped in the state hospital's "revolving door"--an alternating cycle of short-term hospitalizations and brief placements in the community. Or worse yet, whenever these tenuous arrangements gave way, more and more mentally ill took their places among the homeless or the residents of the county jails.

Housing Shortages and Shortfalls Persist. Developments in the 1970s and 1980s have exacerbated the housing situation. At the present time, a greater number of mentally ill individuals are competing for each unit of possible housing. Moreover, in the housing that remains, rents have increased at a rate greatly exceeding income.

- Nearly one million single-room occupancy hotel rooms were destroyed between 1970 and 1982, as part of downtown renovation and urban renewal efforts. Roughly 33 percent of these rooms had been rented to the chronically mentally ill (3, p. 4).

- Federal public housing programs have been substantially reduced. In 1980, Section 8 housing subsidies and public housing program funds amounted to $26.7 billion, with an additional $3.7 billion provided for the construction of new public housing; in 1983, $8.6 billion was provided for housing subsidies and funds, without any additional funds provided for the construction of new housing (4, p. 4). Two decades of inflation and unemployment have also produced burgeoning waiting lists for existing public housing.

- Federal funds for general mental health and social services have decreased, weakening those reciprocal parts of residential programs that depend on such services for their success. The Reagan administration is proposing $11 million in cuts from the mental health community support program in FY 1987.

- In 1981, the Reagan administration ordered administrators of the Supplemental Security Income Program to review regularly the continued eligibility of beneficiaries. As a result, benefits were terminated for a large number of mentally ill, dependent on such income to meet basic needs of food and shelter. These changes augmented problems already posed by the traditional lack of syncronization between federal aid programs and state hospital discharge policies.

- Public prejudice against the mentally ill remains a problem that often translates into action. While states have worked to combat exclusionary zoning ordinances, localities have begun to invoke the power of private land use regulations and restrictive covenants to block the establishment of community residences for the mentally ill. In addition, a small percentage of the communities that did not or could not block the establishment of such residences during the last twenty years have been overrun by them, creating "social service ghettos" and entrenching resistance to the mentally ill in many remaining communities.

GENERAL LEGISLATIVE GUIDELINES

As an important component of community-care for the mentally ill, housing is a combination of critical elements. Not only is stable, affordable housing needed, but it must be linked with support services in order to be effective. As such, state legislators may want to consider the housing and support needs of the mentally ill in an integrated fashion to maximize the state dollars they invest in community treatment and support programs.

Yet lawmakers would do well to remember that the housing needs of the mentally ill are really no different from those of "normal" people: they need a

roof over their heads and a support system they can turn to in times of trouble. Specifically, they need to be able to obtain help when they are in crisis, they need assistance making important transitions, and they need long-term, indefinite supports.

In brief, an adequate residential treatment program for the mentally ill would include: affordable, low-income or subsidized housing; a location near support services and public transportation; a non-threatening community atmosphere encouraging independent living; linkage to a range of services, including crisis intervention, case management, vocational rehabilitation and socialization programs; and the continued availability of these critical services over time.

The traditional, theoretical continuum of residential services includes such transitional services as those listed below. It is important to note, however, that very few communities have this continuum of transitional programs.

- quarter-way houses, providing a highly structured and supervised environment for those mentally ill who are marginally beyond needing the total care and supervision of a hospital or whose history of chronicity is marked by persistent, acute episodes and a failure to develop even basic living skills;

- halfway houses, providing 24-hour supervision and structure for those mentally ill who are hopefully making the transition to a less restrictive living environment;

- three-quarter way houses, providing a final, semi-supervised environment for those mentally ill who are beyond needing the continual supervision and structure of a halfway house, but who are not ready for a largely independent living arrangement in, for example, an apartment;

Traditional, theoretical models for long-term residential care include:

- semi-supervised, independent apartments for those mentally ill who still require some supervision and assistance in meeting their basic living needs, but whose illnesses are largely in remission and who have achieved a high degree of autonomy;

- family care homes, providing supervised placement in private homes for those mentally ill who cannot withstand the stress of living with other individuals in a halfway house or supervised apartment.

Models for emergency assistance and crisis stabilization generally include respite apartments and crisis stabilization units, providing a highly structured and supervised program for the temporary care of those individuals who have achieved a certain degree of independence, but who are suffering a temporary crisis.

Increasingly, however, mental health administrators and advocates are turning away from the traditional residential models, which are often heavily congregated and staffed, incite the greatest community opposition and maximize the dislocation of the client. Instead, they are focusing on housing programs

that provide stable living arrangements augmented by varying degree of support. These programs can often be less expensive than the traditional models for residential care.

Beyond addressing gaps in the range of residential services available to the mentally ill, state legislators can do much to promote adequate housing for this population in general. Lawmakers may want to consider action in the following areas:

- coordinating service providers, government agencies and funding sources;
- offering development incentives for public and private community residences;
- striving for equitable dispersion of residential facilities through pre-emptive zoning or site-selection laws;
- improving control and coordination of public and private residences through common regulations and standards;
- accelerating efforts to provide a continuum of community-based services, with housing as an integral part of the treatment process;
- involving consumers and family members in housing efforts, as they directly experience the strengths and weaknesses of a state's residential care program and can provide a very useful perspective;
- acknowledging that the housing problem is large and persistent and requires a long term commitment;
- adopting a posture of hope and optimism for the future, as many lessons have been learned about how to care effectively for the mentally ill.

THE STATES' RESPONSE IN RECENT YEARS

State legislators have acted to address the housing needs of the mentally ill in a number of ways. To begin with, roughly one-third of the states have acted to combat the "zoning out" of housing for the mentally ill. States that are actively considering pre-emptive zoning legislation in 1986 include Alabama and Hawaii.

California, Michigan, New Jersey (children only), New Mexico, South Carolina and Wisconsin, are among those states that have overriden exlusionary zoning by stipulating that the residents of a group home constitute a "family" for residential zoning purposes. Other states prohibit ordinances that discriminate against the mentally ill in zoning matters.

- Oregon (1983 Or. Laws, chap. 293) stipulates that a city or county may impose zoning restrictions on the operation or maintenance of a residential facility for the mentally ill provided that they are no more restrictive than conditions imposed on similar residential dwellings in the same area.
- Texas (1985 Tx. Gen. Laws, chap. 303) defines community homes for six or less disabled persons, including the mentally ill, as a "permitted use" or a home in all residential and other zoning districts in the state, while

rendering void any regulation or restriction on the use of the land relating to the transfer, sale or lease of the property.

In a similar vein, states have attempted to override local objections by protecting against the clustering of facilities. In 1985, for instance, Utah (1985 Utah Laws, chap. 105) authorized the establishment of residential facilities for the mentally ill in all residential zones except those slated for single-family homes, but stipulated that such homes cannot be established within one mile of each other. Wisconsin overrode all local zoning in authorizing residential facilities serving mentally ill children and adults in all residential zones (1977 Wis. Laws, chap. 205) in an attempt to force equitable dispersion of group homes.

States have also attempted to intervene in siting battles. New York established a specific site-selection process for group homes for the mentally ill, involving both the group home operator and the local municipality (1978 N.Y. Laws, chap. 468). Siting procedures that would have required such action as prior approval by the local legislative body (Connecticut) or written notice of intent to establish a group home provided to local citizen's groups and adjacent property owners (Maryland) were proposed, but did not pass, in 1985 and 1986.

Other states have adopted legislation aimed at developing a range of residential facilities. Examples include:

- Arizona (1984 Ariz. Sess. Laws, chap. 389) mandated the development of a statewide plan for a community residential treatment system, stipulating that the state may require no more than a 25 percent match of local or other funds in the establishment of a residential program;

- Hawaii (1980 Ha. Sess. Laws, act 221; 1985 Ha. Sess. Laws, act 219) provided guidelines for the establishment of a state wide system of residential treatment programs that provide a range of alternatives to institutional care;

- Louisiana (1981 La. Laws, act 770) established a Community Residential Program Development Fund to provide loans to cover initial expenditures related to starting community residential programs;

- New York (1984 N.Y. Laws, chap. 298) authorized the commissioner of mental health to establish a continuum of community residential services, outlining standards for the operation and funding of such facilities and providing up to 100 percent state reimbursement of certain costs associated with these programs.

Related legislation in Illinois and Rhode Island addressed the issue of client support in residential facilities. Illinois (1985 Ill. Laws, P.A. 94-918) aimed to secure and maintain adequate financial benefits for those admitted to or released from a state hospital or a community residential program by requiring interagency agreements to that effect. Rhode Island (1982 R.I. Pub. Laws, chap. 363) extended the legal protection already afforded the mentally ill in institutions to the mentally disabled placed in community residential facilities.

States have also addressed the housing needs of specialized populations, especially those of mentally ill children and the mentally ill homeless. Examples include:

- Indiana (1984 Ind. Acts, P.L. 216) mandated the development of a plan for residential treatment programs for emotionally disturbed or substance abusing children;

- New Jersey (1984 N.J. Laws, chap. 180) authorized a program providing temporary rental or other housing assistance to persons who are homeless or in imminent danger of homelessness and encouraged increased availability of low-income housing through the provision of low-interest loans;

- New York (1981 N.Y. Laws, chap. 947) authorized residential treatment facilities for children and youth organized around the principle of single port of entry and exit. The state also created the Homeless Housing and Assistance Program (1983 N.Y. Laws, chap. 61), establishing separate funds for housing assistance to the homeless and for emergency shelter facilities, as well as a third, state-approved residential program for the mentally ill: a residential care center for adults, aimed to meet the housing needs of those mentally ill (often homeless) who cannot obtain appropriate placement in family care homes or in community residential programs (1985 N.Y. Laws, chap. 351).

During 1986, states that have considered or are presently considering other legislation relating to residential services for the mentally ill include New Hampshire, Pennsylvania and West Virginia.

FUTURE IMPLICATIONS AND DIRECTIONS

Today's statistics indicate that obtaining appropriate housing is still a major problem for many mentally ill. For example, among the estimated two million seriously mentally ill living in the United States, 800,000 still live with their families, 300,000 live in nursing homes, 200,000 are in inpatient facilities, 150,000 live on the streets or in public shelters, and 26,000 are in jail or prison (5, p. iii).

The majority of mentally ill have not, in fact, been deinstitutionalized to or placed in an integrated setting in the community; they have been "transinstitutionalized" to other care environments, such as nursing homes and board-and-care homes that simply do not provide many of the services they need to function at an optimal level. For instance, although three-fourths of the residents in board-and-care homes have been institutionalized and demonstrate behavioral problems, these facilities generally do not provide trained mental health or professional staff (6, p. 17). Housing remains a problem not easily solved, nor avoided.

During the upcoming 10 years, federal money for public housing, general social services and mental health services will probably continue to decrease. States are going to have to look increasingly within their own borders for the help they need.

Many states are already acting. They are taking steps to improve their public mental health systems, recognizing the importance of appropriate housing in the continuum of services. They are opting for small, scattered

residential programs that minimize community resistance and client dislocation. They are redirecting state funds from the hospital to the community. They are taking steps to coordinate mental health services, thus working to ensure that the complementary elements of the community-based system are sufficiently in place to support one another. They are drawing up statewide blueprints for essential residential and other mental health services. They are directing resources toward problem populations--those who most often find themselves on the streets or in jail--in an effort to close daunting service gaps. And they are being rewarded.

Moreover, the courts, which have long taken part in the debate over housing for the mentally ill, have recently handed down some key decisions in support of community-based housing for the mentally ill. State supreme court cases have already been decided on both sides of the issue in California, Connecticut, Georgia, Iowa, Maine, Minnesota, Montana, Nebraska, New Hampshire, Ohio and Virginia. Yet advocates for the mentally ill are particularly hopeful that two 1985 federal court cases will help their cause in the future.

- In J.W. vs. City of Tacoma, Washington, 720 F.2d 1126 (9th Cr. 1983), the federal Ninth Circuit Court of Appeals ruled unconstitutional a local zoning ordinance that required an operator of a residential facility for former mental patients to obtain a special use permit when similar facilities for different residents could operate without a permit. The court held that the "Tacoma ordinance plainly 'discriminates' against former mental patients in that it singles them out for special treatment solely because of their medical history."

- In Living Centers vs. City of Cleburne, TX, 473 U.S., 87 L.Ed. 313, 106 S.Ct. 260 (1985), the U.S. Supreme Court struck down a local ordinance that required a special use permit for a proposed group home for the mentally retarded because the city could not prove that the home would "pose any special threats to the city's legitimate interests" beyond those posed by the boarding houses and hospitals that were already allowed to locate in the area without a permit.

Yet the years to come promise to bring increased demand. Problems with inadequate funding and integration of housing and support services can only increase with time. Moreover, inadequate benefits may keep many mentally ill at a level where poverty--and not illness--place many potential places to live out of reach. Moreover, those who do find a place to call home may still have to face the stigma associated with mental illness: the community may not want them there. Thus state legislators will want to incorporate many different interests in their long-range efforts to solve the problem of housing for the mentally ill.

CASE STUDY: HOUSING FOR THE MENTALLY ILL IN VIRGINIA

INTRODUCTION

The Virginia Committee on Housing for the Disabled reported in July 1985 that housing for the mentally ill exists in the state, but it is often unaffordable and inadequate. Moreover, data on both existing housing and clients needing facilities is minimal and makes the provision of facilities and services throughout the state difficult to assess (7, p. 10). Existing residences are often not fully utilized, and proposals for new housing projects for the mentally ill often are not marketed in such a way as to encourage the housing industry's interest.

In 1968, the Virginia Legislature authorized the development of local Community Service Boards (CSBs), charged with monitoring mental health treatment efforts within communities and providing a range of services, including regular counseling and extensive support services. Today, 40 boards serve over 39,848 clients, and the interaction of CSBs with local housing programs for mentally ill is increasing (8, p. 3). In 1986, the Virginia Legislature passed a law requiring CSBs to execute annual, written agreements with local housing authorities, specifying what services will be provided to mentally ill clients (1986 Va. Acts, chap. 92).

Current state housing policies, however, do not mandate CSBs to provide residential services. To date, 29 boards provide residential programs. Yet the boards generally lack stable sources of funding to provide uniform services statewide. Moreover, existing law does not ensure continuous local government support for the expansion of community services, nor does it specify a local government's "fair share" in financing housing. According to records of previous expenditures, nine localities contributed less in FY 1985 than FY 1981, and 15 localities maintained or decreased FY 1985 levels for CSB services from the year before (9, p 105).

Homes for Adults (HFAs) have gradually become Virginia's private sector alternative to the problem of housing for the mentally ill. HFAs have flourished in the many communities that lack sufficient funds to provide adequate residential treatment programs. Some HFAs adhere to minimal regulations imposed by the Virginia Department of Social Services, but many facilities operate unlicensed. HFAs will necessarily complicate efforts to meet the housing needs of the mentally ill in a comprehensive fashion. No single agency monitors individuals placed in HFAs. Moreover, HFAs are not adequately linked to support services, 25 percent do not collaborate with CSBs, 35 percent provide no day activities, 55 percent have no transportation to CSB programs, and 43 percent receive no mental health training from CSBs (9, p. 113).

Recognizing the difficulties posed by the unregulated proliferation of HFAs, the Virginia Legislature, in 1986, took several preliminary steps towards resolving the HFA problem. To increase communication between CSBs and HFAs, state lawmakers passed a bill requiring predischarge plans for state hospital residents to state explicitly if the individual about to be released will reside in a HFA (1986 Va. Acts, H.B. 356). Furthermore, the state Departments of Social Services and Mental Health/Mental Retardation have been mandated to conduct a joint study of the aftercare needs of mentally disabled clients in HFAs (1986 Legislative Session, H.J.R. 70).

In November 1985, the NCSL Mental Health Project provided Virginia with a technical assistance program on meeting the housing needs of its mentally ill population. The state's problems relative to housing were outlined by state legislators and staff involved with mental health issues and derived from various legislative and state documents. The suggestions provided to Virginia reflect those of the consultants involved in the program and do not necessarily reflect those of NCSL or the National Institute of Mental Health (NIMH). Consultants for the Virginia program included Dr. Paul Carling, director, National Research, Training and Dissemination Project, Boston University, Boston, Massachusetts, and Dr. David Goodrick, associate director, Alpha Center, Washington, D.C.

ROADBLOCKS: IDENTIFYING PARTS OF THE PUZZLE OF HOUSING FOR THE MENTALLY ILL

Financing. The question of who will pay for the community-based housing and treatment of Virginia's mentally ill has a complicated answer. Funding for such programs comes from a variety of federal, state and local sources. Across the board, funds are diminishing while the demand for services is increasing.

- Virginia spends slightly less than the national average per capita for mental health services. While Virginia spends more than the national average per capita for state hospital services, the state trails the national average per capita for community services by almost 50 percent (9, p. 24). Thus communities have often had less money than needed to develop the appropriate residential services for the majority of the state's mentally ill who live there.

- The financing of low-income housing for the mentally ill presents a greater problem than the financing of low-income housing for the general population because funds are needed for both housing and support services. As a result, shelter and non-shelter budgets are separate, and the various funding sources must be coordinated. Funds for actual housing can be obtained through federal HUD and FHA grants and loans, technical assistance programs provided by the state Department of Housing and Community Development, and low-interest mortgages and federal loans and grants administered by the Virginia Housing Development Authority. Local redevelopment, housing authorities and city governments contribute as well. Sources of funds for support services include U.S. Department of Health and Human Services assistance, state contributions from the Department of Mental Health and Mental Retardation, the Department of Social Services and the Department of Health (7, p. 15).

- The Virginia Housing Development Authority is working to develop state policies to stimulate financing for construction and renovation of low-cost housing for the mentally ill, including the possibility of a state-funded subsidy program. In addition, the Department of Mental Health and Mental Retardation has prioritized funding since 1981 for residential support services, including case management, day treatment and transportation. Yet funds for these efforts have not always been forthcoming from the General Assembly.

- The state's Auxiliary Grant program was established in 1974 to supplement federal SSI payments made to Virginia residents in licensed Homes For Adults when their SSI benefits were insufficient to cover the rate charged

by such homes, even when combined with other resources. During the last five years, the program has expanded the number of cases it supports by 88 percent, and program expenditures have risen 409 percent. Funding for the program is shared 62.5 percent by the state and 37.5 percent by local sources. During the 1986 session, the Virginia Senate passed a joint resolution expressing support for the expansion of the auxiliary grants program to include mental health clients in CSB facilities and requesting the Departments of Social Services and Mental Health and Mental Retardation to develop a plan to incorporate these facilities (1986 Legislative Session, S.J.R. 62).

Community Opposition and Zoning. Community opposition has frustrated efforts to establish residential treatment facilities in many locations in Virginia.

- While state law overrides local zoning control over group homes, they are kept from many preferable residential neighborhoods because of a 1984 Virginia Supreme Court decision in Omega Corporation of Chesterfield vs. Malloy, 319 S.E. 2d 728 (Va. Sup. Ct. 1984). The court upheld a lower court's 1981 decision that occupancy of a home by unrelated persons who live with a counselor does not constitute "single-family use," and thus can be blocked by restrictive covenants. In 1986, the legislature passed a bill to override the power of restrictive covenants in the establishment of group homes, but housing advocates had already suffered many setbacks as a result of the court's decision.

- While state law stipulates that the number of community residences in a given area should ideally be proportional to local population and density (Va. Stats. Ann. 15.1-486.2), the ghettoization of community residences is still a problem in certain communities.

Leadership. The lack of a cogent state policy promoting adequate community-based housing for the mentally ill has also posed significant problems. As yet, no single state or local agency has a specific statutory mandate to address the comprehensive shelter and non-shelter needs of the mentally ill (7, p. 10). Yet many of the problems traditionally posed by a lack of leadership on this issue soon may be ameliorated. During the 1986 session, the legislature passed a bill establishing the Interagency Coordinating Council on Housing for the Disabled (1986 Va. Acts, chap. 244). The Council is slated to provide "cross-secretariat interagency leadership" for the comprehensive planning and the coordinated implementation of housing proposals and to develop a state policy on housing for the disabled.

POSSIBLE SOLUTIONS FOR VIRGINIA

Regarding the financing of housing for the mentally ill, Virginia could consider the following options:

Establish incentives to bring together the various interest groups that would necessarily be involved in solving the problem of housing for the mentally ill at the local level. Such incentives might include establishing state funding priorities that would encourage local housing and mental health authorities to begin working together. Incentives to involve the private sector might include requiring local, private-sector matching funds for every state dollar awarded for housing. Such incentives would help create funding

arrangements for local residential programs that are at least as attractive as those for inpatient treatment;

Recognize the high interdependence between housing and inpatient services and increase efforts to tranfer funds from the state hospitals to the communities. Mentally ill individuals often remain in state hospitals because there is no appropriate place for them to live in the community; similarly, many return to hospitals because the residential and support services available to them in the community have proved inadequate. Housing is key to reducing utilization of inpatient services.

In shifting its state hospital resources, Virginia could use some of the same tactics employed by Wisconsin when it went from being one of the most institutionally oriented states to one with a strong community-care foundation. Wisconsin passed legislation establishing local mental health boards and giving them treatment responsibility and authority. Subsequently, Wisconsin reduced the number of its inpatient beds from 13,000 in 1963 to 2,000 in 1974 to 1,100 currently, made its involuntary civil commitment law more restrictive, and actively promoted the establishment of local community support programs.

Regarding opposition to community-based housing for the mentally ill, Virginia could consider action in the following areas:

Assist communities in combating the opposition that inevitably occurs by authorizing or mandating the state mental health agency to provide direct assistance to the communities encountering resistance. The state agency could help local mental health planners minimize resistance by working with them to promote the community residence and by helping them choose the residential treatment model that will meet with the least amount of resistance in the given community (i.e., larger facilities tend to incite greater opposition than smaller facilities in more residential areas);

Protect the right of the mentally ill to locate in the community by stringently enforcing state laws overriding the power of local zoning regulations and restrictive covenants. The state may also want to consider developing a formal site selection procedure for community residences. Such laws can force equitable dispersion of homes and further the goals of reintegration and acceptance of the mentally ill.

Regarding the need for a clear housing policy, Virginia could do the following:

Develop a clear interagency plan for meeting housing needs over the next five years. Such a plan can clarify who is responsible for various services, who needs to be involved in meeting the housing needs of the mentally ill, etc. The report of the Virginia Committee on Housing for the Disabled is a good start, as is the transition plan developed by the Department of Mental Health and Mental Retardation, but the state might want to focus specific attention on a set of agreed-upon goals relative to housing for this population;

Act to dispel the notion that everyone with psychiatric disabilities needs the 24-hour supervised care provided by a group home by striving for a better balance between highly supervised facilities and other housing alternatives. The vast majority of mentally ill individuals do not require 24-hour or even intermittently staffed residential facilities. Yet if the state spends 80

percent of its funds on inpatient services or on highly supervised residential settings, the 80 percent of the mentally ill who do not require treatment-intensive settings will end up returning to them;

Strive for a more practical state/local partnership and for an integrated financing system that involves housing and social service agencies at both the state and local level. Successful state housing problems must be able to account for local differences in housing stock, ideal program models, etc. States that have developed a comprehensive approach to housing for the mentally ill have developed mechanisms for encouraging planning at the local level, supported by state initiatives. For example, Massachusetts has a program that aims to bring together human services, economic/community development, housing and mental health interests in a collaborative effort to address a given locality's housing needs. Whenever the local agencies decide to join together to solve the housing problem on a community-wide basis, the state provides funds to develop the local plan. Once the plan is submitted to the state, it is jointly funded by the human service and housing agencies;

Take a comprehensive approach to housing in any legislative effort. States need to balance their efforts between what kind of facilities will be needed and what kind of services will be needed to maintain the mentally ill individuals in those facilities. States may want to consider action in the following areas in conjunction with any legislative effort to address the mentally ill's housing needs: funding staff for housing assistance programs as well as staff for the actual facilities; authorizing training for traditional mental health staff to teach them how to help the mentally ill meet their housing needs (i.e., how to help them find housing, maintain housing, develop basic living skills); and establish some type of rental subsidy program targeting the mentally ill;

Improve accountability of housing services. State legislators have a right to ask questions about whether or not a system is meeting the needs of the mentally ill population in its area and to condition future funding on adequately meeting those needs;

Aim for clarity about the goal of any rehabilitative residential program at both the state and program level: to help a mentally ill individual remain and be successful in the living environment he has chosen with a minimal amount of help from formal systems. A mentally ill individual will need help making the transition into a housing program, but will also need the availability of long-term support if he or she is going to remain in that residence. To this end, some states are experimenting with a departure from the traditional residential program model, emphasizing the individual's progress through a series of buildings (i.e., from one-quarter way house to halfway house to three-quarter way house), to providing the individual with long-term, stable housing from the beginning and merely modifying the level of the support services as the individual's needs change. This approach can eliminate much of the dislocation produced by moving through a series of buildings for this often stress-sensitive population;

Recognize that the housing needs of the mentally ill are a community and state problem and not an exclusive mental health problem. Thus states can act to involve the various interests that must be involved in the successful resolution of the housing dilemma, including mental health, housing, social services and the private sector.

CONCLUSION

In Virginia, as in many states, progress toward adequate community-based housing for the mentally ill is slow. Yet the state has already taken significant steps to accelerate its progress toward that goal. Legislative efforts such as the Task Force on the Housing Needs of the Disabled point toward a concern for this group that is both genuine and focused. Virginia must remember, however, that concern is often not enough. The state must continue to explore different avenues to meet the housing needs of this highly dislocated and often helpless group.

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TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIALS

Available through the NCSL Mental Health Project are edited tapes of the actual technical assistance program presented for Virginia in November 1985, as well as the background materials distributed at the program.

The tape of Virginia's technical assistance program, entitled "Housing for the Mentally Ill," features Dr. Paul Carling, National Research, Training and Dissemination Project, Boston University, Boston, Massachusetts, and Dr. David Goodrick, Alpha Center, Washington, D.C. Dr. Carling discusses the issues involved in meeting the housing and rehabilitation needs of the psychiatrically disabled. Dr. Goodrick addresses the issues involved in comprehensive mental health planning and its implications for housing.

Background materials relating to housing for the mentally ill include a summary of select state legislation, a discussion of model programs, a bibliography and a checklist that interested legislators and staff may return for copies of legislation and bibliographic materials.

If you wish to receive loan copies of these tapes, or the background information distributed at the technical assistance programs, please copy, complete and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, CO 80265.

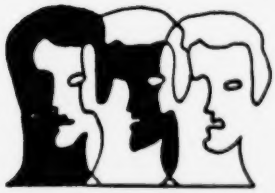
Name: _____

Title: _____

Address: _____

_____

Requesting Virginia background materials ___ tapes ___



MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In February 1985, the National Institute of Mental Health (NIMH), U. S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues.

The goal of the NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information surrounding mental health issues.

Through this fourteen month program, the Mental Health Project can respond to specific issue and format needs of legislators. By involving the Panel of Experts, a group composed of legislators and persons with mental health experience, expert consultants, and state policy makers, programs will be developed to provide a variety of services to states, including testimony, special workshops and seminars, and staff assistance.

Based upon input from the state legislatures, ten states were chosen to receive technical assistance with state-specific mental health issues. Along with the programs, background materials, audio tapes, and a State Legislative Report will be developed for each issue area and are available free of charge to requesting parties. The scheduled technical assistance programs include:

South Carolina	Involuntary Civil Commitment	May 10, 1985
California	Mentally Ill Homeless	August 7, 1985
Missouri	Mental Health Services Coordination	September 24, 1985
Kentucky	Mental Health Services for Adolescents	October 3-4, 1985
Pennsylvania	Revolving Door Syndrome of Mental Health Services	October 23, 1985
Virginia	Housing for the Mentally Ill	November 18, 1985
Oklahoma	Community Care for the Chronically Mentally Ill	December 4-5, 1985
New Hampshire	Mandated Mental Health Insurance/ Mental Health Services for the Elderly	January 9, 1986
Michigan	Mentally Ill Offender	January 28, 1986
Oregon	Mental Health Services Funding	March 4, 1986

The Mental Health Project Manager is Rebecca T. Craig, who may be contacted at NCSL's Denver office (303) 623-7800. The federal project officer is Lee Dixon, Office of Policy Development, Planning, and Evaluation, National Institute of Mental Health, at (301) 443-3175.